1997 Annual Report to the Legislature

Health Care Authority

January 1998

HCA 62-100 (1/98)

Overview of the Health Care Authority

The mission of the Health Care Authority

Provide access to quality, affordable health care coverage for public employees, retirees, Basic Health enrollees, people served by community clinics, and others authorized by the Legislature.

To accomplish this mission:

We carefully use the state's resources to offer choice of coverage, model purchasing and payment practices, advise the state of Washington on health care purchasing issues and policy formulation, and enhance the quality of health care delivery and access to care in Washington State.

Public Employees Benefits Board (PEBB)

Services:

- Comprehensive medical and dental benefits
- Life and long-term disability insurance

Provided for:

- State employees and retirees
- School district employees and retirees
- Employees of political subdivisions

Delivered by:

- Managed care medical plans
- Uniform Medical Plan (state's preferred provider organization administered by the Health Care Authority)
- Managed care dental plans
- Uniform Dental Plan
- Life and long-term disability insurers

Washington Basic Health Plan

Services:

- Health benefits package including preventive care and prescription drugs
- Expanded benefits (including dental and vision) for children at or below 200 percent of federal poverty level through a partnership with Medicaid

Provided for:

- State residents who are not eligible for Medicare
- Those at or below 200 percent of the poverty level receive assistance with premium costs

Delivered by:

- Managed care medical plans

Primary Health Care Services

Services:

- Grants to provide medical, dental, and migrant health services

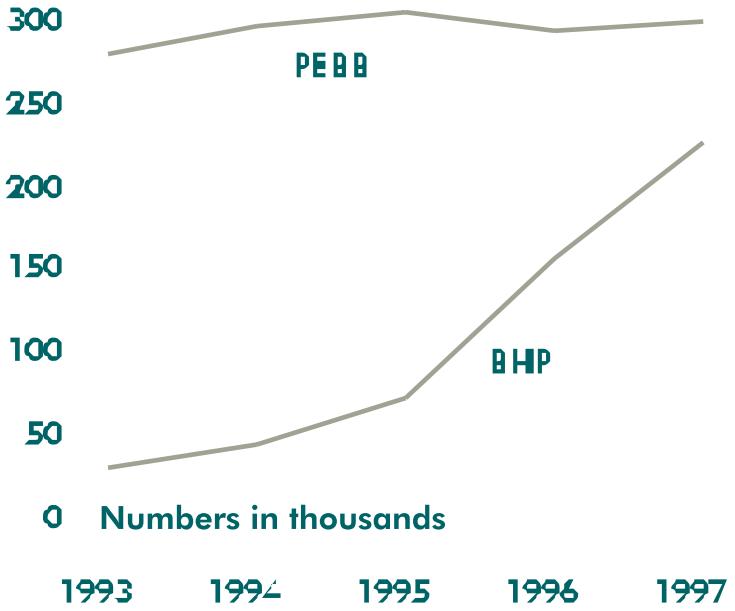
Provided for:

- Populations without, or with limited access to, comprehensive medical or dental services. These populations include low income, homeless, refugees, elderly, migrant, and other minority populations

Delivered by:

- Urban and rural community clinics

Public Employees Benefits Board (PEBB) and Basic Health (BHP) enrollment growth



HCA Total Enrollment (As of June 30, 1997)

Product Line	Total Enrollees (including Spouse & Dependents)
State Actives	224,414
School District Actives	4,858
Political Subdivision Actives	5,853
State Retirees	29,801
School District Retirees	24,427
COBRA and Others	3,240
Subtotal PEBB	**292,593**
Basic Health Reduced-Premium (subsidized)	129,308
Basic Health Plus Children	66,451
Basic Health Full-Premium (non-subsidized)	24,045
Subtotal BHP	**219,804**
TOTAL	**512,397**

Does not include persons served through Primary Health Care program.

1997 Major Highlights

Joint procurement

The HCA teamed with the Medical Assistance Administration (MAA) from the Department of Social and Health Services to conduct a combined health plan contractor selection process for insurance programs administered by the two agencies.

The joint procurement, the first of its kind in the nation, resulted in contract awards which will provide health care coverage to more than 900,000 Washington residents. The interagency bidding process involved contracts for Public Employees Benefits Board (PEBB), Basic Health, and MAA's Healthy Options program.

The joint procurement was the first of its kind in the nation.

The two contracting agencies developed common standards covering quality improvement programs, provider network access, financial status, and information reporting requirements. Plans submitting bids were jointly evaluated on the basis of their legal and financial status, quality improvement programs, provider network access, and rates.

Outpatient prospective payment system project

In another interagency effort, the HCA, the Department of Labor and Industries, and MAA worked to develop an Outpatient Prospective Payment System (OPPS). The project brings the three agencies together to develop and implement a system for reimbursement of outpatient hospital costs, facility costs billed by ambulatory surgery centers, and may apply to costs for physicians with surgical suites as well. Project objectives are to reinforce uniformity in state reimbursement methodologies and provide agencies with useful data about the outpatient services they purchase, including data which can be used to analyze current and predict future outpatient utilization.

The HCA is the lead agency with responsibility for project management and consultant contracting, as well as systems development and implementation for the Uniform Medical Plan. The HCA issued a request for proposals in October 1997 seeking a nationally recognized consultant to assist on the project from early 1998 through June 1999.

Health status-based risk adjustment

The HCA is implementing a refined risk assessment methodology to adjust payments for the 1998 PEBB contracting cycle. Previously, the relative risk of contracting health plans was calculated solely on the demographic characteristics (age, gender, member status, and family type) of each plan's enrollees. In 1998, these demographic characteristics will be expanded to include enrollees' COBRA and retiree status. In addition, phase-in of a health status-based risk adjustment approach will expand the risk calculation to include a measure of health status based on enrollees' recent diagnostic experience.

Health status-based risk adjustment increases the sensitivity of plan payments to the treatment needs (and costs) of enrollees with different risk characteristics. Without undermining the insurance aspect of managed care plans, it encourages enrollment of all health risk classes by more accurately reflecting the relative risk of enrolled populations in the payments made to contracting plans.

Consumer Assessment of Health Plans Survey

To provide better purchasing information for enrollees, nearly 16,000 state and higher education employees were surveyed about their experiences with 20 health plans that contract with the PEBB. Funded in part by a federally supported demonstration project, the Consumer Assessment of Health Plans Survey (CAHPS) report shows how fellow state employees responded to a series of questions about their experiences with the various health plans.

The report gave members a picture of peers' experiences with PEBB health plans.

The survey is believed to be one of the first of its kind in the nation. An evaluation, which began in late 1997, will assess the survey project, especially how consumers used the information. Other state agencies are looking at similar technologies to measure the quality of plans offered to their enrollees.

Long-term care insurance product

Work has continued on the development of a long-term care insurance product. The 1996 Washington State Legislature directed the HCA to develop a voluntary long-term care insurance plan for public employees, retirees, and other eligible persons by January 1, 1998.

Enrollment for the new PEBB long-term care insurance product should begin in the spring of 1998.

In late 1997, the agency selected an apparent successful bidder (John Hancock Mutual Life), even though responses to a request for bids were less than encouraging. After determining that the benefits recommended by an advisory panel would have resulted in a package beyond the means of most potential customers, the HCA began seeking an already-existing package. An education campaign will begin early in 1998 with enrollment beginning in the spring of 1998.

Clinical Outcomes Assessment Program (COAP)

The HCA, on behalf of the Interagency Quality Committee, is working with a representative group of providers of cardiac services, the Foundation for Health Care Quality, and others on the Clinical Outcomes Assessment Program (COAP).

COAP began in 1994 as a Robert Wood Johnson sponsored project to examine the feasibility of collecting, analyzing, and disseminating Washington cardiac surgical outcome data to improve quality.

COAP continues to focus on opportunities for improvement in high-cost, high-volume specialty services, such as cardiac revascularization. The eventual goal is for hospitals and provider groups in Washington State to have a mechanism to effectively develop, implement, and evaluate sustainable quality improvement programs, while maintaining patient confidentiality. Health plans, purchasers (including the HCA), and consumers would benefit from the medium- and long-term improvements in cost effectiveness, appropriateness, and quality of care.

Statement of Revenues, Expenses, and Fund Balance

1995-97 Actuals	PEBB	BHP Non-Subsidized*	BHP Subsidized	Primary Health Care	Health Care Planning	Total Customer Lines
Revenues						
Premium Charges/Other	$914,570,486	$30,153,041	$ 34,069,082	$ -	$ -	$ 978,792,609
Direct Appropriations	-	-	241,420,000	12,408,866	2,236,177	256.065,043
Underspend of Appropriations	-	-	(8,091,843)	(27,623)	(789,898)	(8,909,364)
Total Revenues	**914,570,486**	**30,153,041**	**267,397,239**	**12,381,243**	**1,446,279**	**1,225,948,288**
Expenditures						
Life/LTD Benefits	9,056,830	-	-	-	-	9,056,830
Dental Benefits	115,111,056	-	-	-	-	115,111,056
Medical Benefits	774,242,049	27,227,956	244,157,505	-	-	1,045,627,510
Subtotal Benefits	898,409,935	27,227,956	244,157,505	-	-	1,169,795,396
Community Clinics Grants	-	-	-	11,926,679	-	11,926,679
Administration	14,216,309	1,910,385	23,265,467	454,564	1,446,279	41,293,004
Total Expenditures	**912,626,244**	**29,138,341**	**267,422,972**	**12,381,243**	**1,446,279**	**1,223,015,079**

1997-99 Biennium Budget	PEBB	BHP Non-Subsidized*	BHP Subsidized	Primary Health Care	Health Care Planning	Total Customer Lines
Revenues						
Premium Charges/Other	987,943,249	108,316,402	97,495,000	-	-	1,193,754,651
Direct Appropriations	-	-	306,007,908	12,646,655	2,158,193	320,812,756
Total Revenues	**987,943,249**	**108,316,402**	**403,502,908**	**12,646,655**	**2,158,193**	**1,514,567,407**
Expenditures						
Life/LTD Benefits	10,017,212	-	-	-	-	10,017,212
Dental Benefits	132,404,321	-	-	-	-	132,404,321
Medical Benefits	845,753,739	101,461,102	330,208,000	-	-	1,277,422,841
Subtotal Benefits	**988,175,272**	**101,461,102**	**330,208,000**	-	-	**1,419,844,374**
Community Clinics Grants	-	-	-	11,904,456	-	11,904,456
Agent/Broker Commissions	-	-	270,000			270,000
Administration	15,717,093	3,518,397	25,078,349	742,199	2,158,193	47,214,231
Total Expenditures	**$1,003,892,365**	**$104,979,499**	**$355,556,349**	**$12,646,655**	**$2,158,193**	**$1,479,233,061**

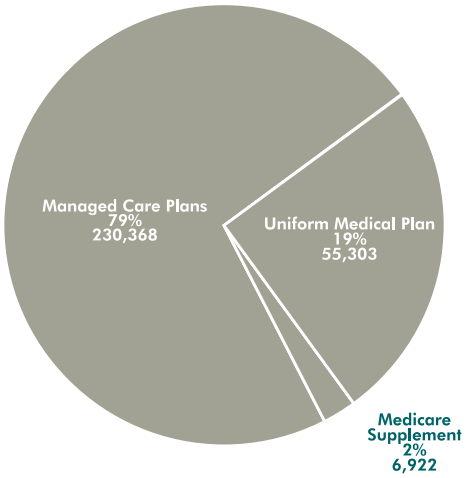
*BHP Nonsubsidized revenue is reported on a cash basis.

1997-99 Admin. as Percent of Total Expenses	PEBB	BHP Non-Subsidized	BHP Subsidized	Primary Health Care	Health Care Planning	Total Customer Lines
	1.6%	3.4%	7.1%	5.9%	100%	3.2%

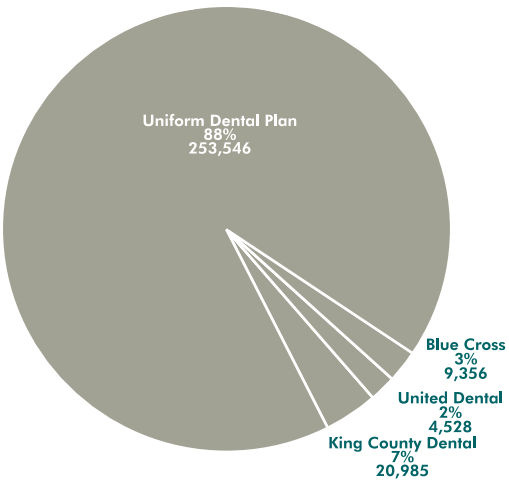
Public Employees Benefits Board

The Public Employees Benefits Board program provides medical, dental, life, and long-term disability insurance for nearly 300,000 members. Members include all state and higher education employees, employees from some school districts and political subdivisions, retirees from state agencies and school districts, as well as the spouses and dependents of these members.

Medical plan enrollment as of June 30, 1997



Dental plan enrollment as of June 30, 1997



Retiree insurance consolidated within the HCA

During 1996, the HCA and the Department of Retirement Systems (DRS) jointly evaluated the process for serving retirees. In an effort to improve customer service and efficiencies in delivering insurance services to retirees, the services were consolidated within the HCA in February 1997. DRS transferred four full-time positions to the HCA to continue providing enrollment and accounting services for the 30,000 retirees served through pension deductions. The agencies' systems interface nightly to coordinate the monthly pension deduction process. The transition of trained staff into the HCA retiree unit has gone smoothly, and retiree services have become more coordinated and seamless.

Retiree access study

The Legislature directed the HCA to work with the Office of the State Actuary (OSA) to review methods to increase retiree access to the PEBB program, and the fiscal impacts of each method. The HCA and OSA have completed projections for state retirement patterns over the next 20 years, as well as projections for participation in the PEBB retiree program over the same 20-year period. Projections show a 74 percent increase in pension retirees by 2017, and a 62 percent increase in PEBB plan participation. Both figures hint at future fiscal concerns for the state that will be explored in the study. Retiree stakeholders have also identified a list of eligibility issues they want explored, including discussion of a second enrollment window for retirees who did not join the program when initially eligible. The study should be available in early 1998.

PEBB enrollees face changes in 1998

As a result of new contracts negotiated for the 1998 plan year, state employees and retirees faced a number of changes in late 1997 when they selected new medical and dental plans for 1998 coverage.

PEBB enrollees found some plans were no longer available in certain areas, that some plan mergers had occurred, as well as changes in benefit enhancements and premiums. But one of the biggest changes was the loss of Blue Cross of Washington and Alaska, and the Good Health Plan of Washington. The state budget directed the agency to maintain the state employees' average premium contribution of $14 per month, and as a result, the HCA was unable to recontract with the highest-priced plans.

PEBB enrollees were faced with changes in benefit enhancements, premiums, plan availability, and the loss of two health plans.

After premium negotiations, the average increase in managed care bids for the active and non-Medicare retirees was 10.4 percent. It is anticipated the average employee contribution will remain at or below $14 per month after open enrollment plan changes by enrollees.

Some of the biggest changes are in store for Medicare retirees. Medical plans experienced significant losses serving PEBB retiree populations during 1996 and 1997. As a result, health plan renewals greatly increased, consistent with HCA projections.

In preparation for 1998 changes, the PEBB sponsored 31 benefits fairs across the state, allowing thousands of employees and retirees to talk with health plan representatives and HCA staff about their plan choices.

Uniform Medical Plan (UMP)

The Uniform Medical Plan is a self-funded, preferred provider plan administered by the Health Care Authority and is the only preferred provider plan available to PEBB members. The preferred provider network consists of: 88 acute care hospitals, more than 8,600 physicians, 51 skilled nursing facilities, 38 alcohol/chemical dependency facilities, 73 ambulatory surgical centers, 120 durable medical equipment suppliers, 76 home health/hospice facilities, 86 naturopathic physicians and acupuncturists, and over 3,100 limited-license physicians/non-physicians. This represents the largest network of its kind in the state.

Enrollment highlights

During 1997, the UMP maintained enrollment levels comparable to those in 1996. The deductible was reduced to $200 per individual with a $600 family cap. These enhancements were combined with a campaign to increase awareness of benefits available through the UMP.

Provider network expands

The UMP expanded its preferred provider network during 1997 to include naturopathic physicians and acupuncturists. Additionally, criteria were developed for the credentialing of Certified Mental Health Counselors and Certified Masters of Social Work as preferred providers. Several innovative program changes were implemented to significantly improve the credentialing and recredentialing processes. The UMP continues to add providers to its network on an ongoing basis.

New reimbursement standards developed

The UMP continued to chair the state's Reimbursement Steering Committee (RSC). Working with the Department of Labor and Industries (L&I) and Medical Assistance Administration (Medicaid) ensures coordination and uniformity in the development of state reimbursement policies and payment methodologies.

During 1997, the UMP took the lead in updating and maintaining the Resource Based Relative Value Scale (RBRVS) fee schedules and payment policy. In addition, the UMP continues to work on development of an outpatient prospective payment system.

Primary Health Care Services

The Primary Health Care Services (PHCS) program continued its mission of providing access to medical and dental care for under-served populations at or below 200 percent of the federal poverty level, and not enrolled in Basic Health or Medicaid. The program is a public/private cooperative effort that provides services to transitional and other populations, over half of them from minority groups (41 percent Hispanic; 6 percent Asian/Pacific Islander; 5 percent African American; 3 percent Native American).

In 1996, the clinics provided service to more than 230,000 medical clients and nearly 79,000 dental clients. Seventy percent of these people had incomes below the federal poverty level. Funding through PHCS helped serve over 121,000 of those patients.

PHCS distributes state funding to 31 community clinic contractors who provide prevention and illness care through more than 100 delivery sites statewide. Without these clinics, these populations would seek treatment at emergency rooms, ultimately at much greater expense to taxpayers.

Patients served by Community Clinics in 1996

Clinic Name	Medical	Dental
Clallam Bay Medical Clinic	800	N/A
Columbia Basin Health Association	9,598	2,278
Columbia Valley Community Health Services	5,733	1,065
Community Care Program, St. Peter's	604	1,944
Community Health Association of Spokane	2,647	1,448
Community Health Care	10,139	3,636
Community Health Centers of King County	16,353	4,865
Community Health Centers of Snohomish County	8,240	5,445
Country Doctor Community Health Centers	9,670	493
Cowlitz Family Health Center	801	N/A
Cowlitz County Health Department (new)	N/A	1
Family Health Centers	7,633	1,196
45th Street Clinic	7,278	1,762
International Community Health Services	3,954	230
Jefferson County Health & Human Services	N/A	1,747
Kitsap Community Health Centers	3,883	306
Community Health Center La Clinica	15,860	4,550
Moses Lake Community Health Center	5,668	2,111
N.E.W. Health Programs	8,395	103
North Whidbey Community Clinic (new)	1,083	N/A
The Opportunity Council	2,127	1656
Pike Market Medical Clinic	3,690	230
Pioneer Square Clinic	2,802	744
Providence Health & Education Center	2,901	161
Puget Sound Neighborhood Health Centers	8,202	11,617
Sea Mar Community Health Centers	24,249	10,293
Seattle Indian Health Board	5,043	2,120
Southwest Washington Health District	N/A	1,748
West Coast Community Clinics	3,762	104
Yakima Neighborhood Health Services	16,340	1,910
Yakima Valley Farmworkers Clinic	42,992	15,064
TOTAL	**230,447**	**78,827**

The Washington Basic Health Plan

The Washington Basic Health Plan is a state-sponsored health insurance program for any Washington State resident who is not eligible for Medicare. All members pay a portion of their monthly premium cost. This cost varies depending on income, age, family size, and choice of health plan. The state offers reduced premiums for individuals and families with lower incomes. The program is funded primarily through taxes collected on cigarettes and alcohol. Basic Health Plus is a Medicaid program for children in reduced-income households. It provides added benefits, and there are no copayments or premiums.

Changes for member costs in 1998

Effective with the 1998 plan year, a smaller percentage of enrollees will pay the minimum monthly premium. In 1997, those earning less than 125 percent of the federal poverty level (FPL) paid the minimum $10 premium. In 1998, only those earning less than 65 percent of the FPL are eligible to pay $10. In addition, the Legislature mandated that managed competition be fully implemented, meaning that only plans submitting the lowest bids for 1998 could offer the minimum premium. The chart below illustrates how these two changes would affect a 40- to 54-year-old individual enrolled in Basic Health.

Income Range	1997	1998
under 65% of federal poverty level	$10.00	$10.00 - $39.66
65% - 100% FPL	10.00	12.00 - 41.66
100% - 125% FPL	10.00	15.00 - 44.66
125% - 140% FPL	10.00 - 20.06	30.60 - 60.26
140% - 155% FPL	10.00 - 29.96	42.08 - 71.74
155% - 170% FPL	10.00 - 39.87	51.00 - 80.66
170% - 185% FPL	19.55 - 49.78	62.48 - 92.14
185% - 200% FPL	29.45 - 59.68	75.23 - 104.89
200% FPL and up	119.00 - 151.00	142.78 - 312.83

Along with those changes, copayments increased effective January 1, 1998. Office visits for a subsidized enrollee increased from $8 to $10 per visit; and from $10 to $18 for a non-subsidized adult. Other major copayments saw similar increases.

Enrollment limits for reduced-premium (subsidized) program

To stay within 1995-97 budget limitations, Basic Health implemented a reservation list in the fall of 1996 for persons interested in the reduced-premium (subsidized) program. By the end of 1996, some 90,000 names were on the list. As current members disenrolled and space became available, enrollment offers were extended to families on the list. However, some 70,000 names were still on the waiting list during the first part of 1997.

The 1997 Washington State Legislature was faced with a dilemma: their desire to add more enrollees to Basic Health while recognizing budget limitations. In an effort to help resolve the issue, it was determined that more enrollees would have to pay a greater share of their health insurance costs. The final 1997-99 budget intended to add 8,000 enrollees to the reduced-premium program by October 1997. However, sufficient funds were not available in the state's Health Services Account to reach this enrollment level.

> In an effort to make the program available to more people, more enrollees would have to pay a greater share of their health insurance

Financial sponsors

Beginning in October 1997, the HCA implemented a legislative budget proviso requiring sponsors that are paid to deliver Basic Health services to contribute a minimum of $30 per enrollee per month. Most sponsors had been paying the minimum premium of $10 per enrollee. Many sponsor organizations chose to discontinue their particupation due to this increase. However two new sponsor organizations not subject to the proviso have offered to take enrollees previously sponsored by the departing organizations. Only about 2,000 members lost sponsorship as a result of the proviso, and they were offered the opportunity to retain Basic Health coverage by paying their own premiums.

The legislative proviso was designed to generate an additional $4.6 million in sponsor contributions during the 1997-99 biennium; however, it is expected to generate less than $500,000 due to the reduced number of sponsors required to pay the $30 contribution.

Key developments

Recertification. Lack of funding has prevented a comprehensive approach to validate member eligibility for the program; however, a pilot system was developed to recertify targeted segments of the Basic Health population.

Improved income reporting and standardized income documentation. The HCA has established more consistent handling of income calculations in determining eligibility for state premium funding. The new forms and materials provide clearer instructions and offer a standardized format, while tightening income documentation policies and providing more uniform guidelines.

Technological advances. An interactive voice response (IVR) capability was added to the automated phone system, allowing callers to access the most frequently requested information without having to speak to a customer service representative. More than 27,000 people used the IVR system to select a health plan during open enrollment. Another advancement is the newly developed document imaging system which greatly speeds up the processing of information and makes for more efficient access and storage of information.

Health Care Authority

676 Woodland Square Loop SE
P.O. Box 42682
Olympia, WA 98504-2682
(360) 923-2600

Basic Health 1-800-826-2444

Executive Management

Gary L. Christenson
Administrator

Judy Lamm
Executive Assistant

Beth Berendt
Assistant Administrator
Health Plan Management

Beau Bergeron
Executive Director
Uniform Medical Plan

Linda Melton
Assistant Administrator
Washington Basic Health Plan

Roger Neumaier
Assistant Administrator
Finance and Administration

Sharon Thompson
Assistant Administrator
Public Employees
Benefits Board Program

Dick Whitten, M.D.
Medical Director

Vicki Wilson
Assistant Administrator
Health Policy, Research,
and Development

Reverend J. William Bertolin

A founding member of the Basic Health Plan Advisory Council, Father Bertolin passed away in 1997. A strong advocate of the poor and disadvantaged, his wisdom will be greatly missed.

Public Employees Benefits Board

Gary L. Christenson, Chair
Health Care Authority
Administrator

Helen Carlstrom
K-12 Retiree Representative

Greg Devereux
State Employee Representative

Sally Fox
Benefits Management Cost
Containment Representative

Eugene Lux
State Retiree Representative

Maureen McLaughlin
Benefits Management Cost
Containment Representative

Gary Robinson
Benefits Management Cost
Containment Representative

Richard D. Rubin*
Benefits Management Cost
Containment Representative

Vacant*
K-12 Representative

* Nonvoting member

Basic Health Plan Advisory Council

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A. Foster Higgins & Company

Andrea Castell
Castell & Associates

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University of Washington

Marc Provence
University of Washington

Leah Layne
Columbia Basin Health Association

Aubrey Davis
Group Health Cooperative

Thomas Milne
Southwest Washington Health
District

John A. Moyer, M.D.
Former Washington State Senator

Robby Stern
Washington State Labor Council

Health Plans Offered

Member Plan Choices (as of June 30, 1997)

Plan Choice	PEBB Total Enrollees	Basic Health Total Enrollees
Blue Cross of Washington and Alaska	10,979	43,164
Blue Cross (Medicare supplement)	6,922	Not Offered
Clark United Providers	Not Offered	3,937
Good Health Plan of Washington†	10,207	20,180
Group Health Cooperative	80,854	19,223
Group Health Northwest	Not Offered	17,718
Health Maintenance of Oregon	589	2,207
HealthPlus	12,755	Not Offered
HMO Washington	994	Not Offered
Kaiser Foundation Health Plan	4,602	7,768
King County Medical Blue Shield‡	30,576	37,430
Kitsap Physicians Service	2,372	5,694
Medical Service Corporation	6,617	14,833
NYLCare Health Plans Northwest	2,011	5,194
Options Health Care	6,369	Not Offered
PacifiCare of Washington	18,844	8,417
Pierce County Medical‡	5,331	16,123
Qual-Med Washington Health Plan	26,901	Not Offered
SelectCare Health Plans	1,343	1,528
Skagit County Medical Bureau	1,216	3,739
Unified Physicians	Not Offered	2,396
Uniform Medical Plan	55,303	Not Offered
Virginia Mason Health Plan	5,354	5,970
Whatcom Medical Bureau	2,161	4,283
Total	**292,593**	**219,804**

† In 1998, Good Health Plan was replaced by Providence Health Plans.

‡ After 6-30-97, King County Medical Blue Shield and Pierce County Medical Bureau merged, forming Regence Blue Shield.

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